DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 2 2

2. STATE: Missouri

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
July 1, 2001

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $352,569
b. FFY 2002 $1,410,278

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19D pages 4, 33A and 60A

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19D page 4 and 60A

10. SUBJECT OF AMENDMENT: This proposed state plan will eliminate the average private pay cap, outline exceptions to the annual cost report filing requirements, expand criteria for providers which qualify for the high volume adjustment and establish a minimum Medicaid per diem rate of $85.00 for nursing facility servics.

11. GOVERNOR'S REVIEW *(Check One)*:

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Dana Katherine Martin

14. TITLE:
Director

15. DATE SUBMITTED:
September 5, 2001

16. RETURN TO:

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
09/06/01

18. DATE APPROVED:
NOV 08 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
JUL 01 2001

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Nanette Foster Reilly

22. TITLE:
Acting ARA for Medicaid & State Operations

23. REMARKS:

cc:
Martin
Vadner
Waite
CO

SPA CONTROL
Date Submitted: 09/05/01
Date Received: 09/06/01

FORM HCFA-179 (07-92)

Instructions on Back

(N) A nursing facility's Medicaid reimbursement rate shall not be limited by its average private pay rate.

(O) The reimbursement rates authorized by this plan shall be reevaluated at least on an annual basis in light of the provider's cost experience to determine any adjustments needed to assure coverage of cost increases that must be incurred by efficiently and economically operated providers.

(P) Covered supplies, such as but not limited to, food, laundry supplies, housekeeping supplies, linens, and medical supplies, must be accounted for through inventory accounts. Purchases shall be recorded as inventory and shall be expensed in the fiscal year the items are used. Inventory shall be counted at least annually to coincide with the facility's fiscal year or the end of the cost report period, if different. Expensing of items shall be recorded by adding purchases to the beginning period inventory and subtracting the end of the period inventory. This inventory control shall begin the first fiscal year ending after the effective date of this plan.

(Q) Medicaid reimbursement will not be paid for a Medicaid eligible resident while placed in a non-certified bed in a nursing facility.

10. Exceptions – A cost report is not required for the following:

A. Out-of-state providers which provide less than one thousand (1,000) patient days of nursing facility services for Missouri Title XIX recipients, relative to their fiscal year;

B. Hospital based providers which provide less than one thousand (1,000) patient days of nursing facility services for MissouriTitle XIX recipients, relative to their fiscal year; and

C. Providers which provide less than one thousand (1,000) patient days of nursing facility services for MissouriTitle XIX recipients, relative to their fiscal year, and have less than a twelve (12)-month cost report due to a termination, change of ownership, or being newly Medicaid certified.

A. Each facility with a prospective rate on or after July 1, 2000, and which meets all of the following criteria shall receive a per-diem adjustment:

(I) Have on file at the division a full twelve (12)-month cost report ending in the third calender year prior to the state fiscal year in which the adjustment is being determined (i.e., for SFY 2001, the third prior year would be 1998, for SFY 2002, the third prior year would be 1999, etc.);

(II) The Medicaid patient days as determined for the cost report identified in part (13)(B)10.A.(I) exceeds eighty-five percent (85%) of the total patient days for all nursing facility licensed beds;

(III) The allowable cost per patient day as determined by the division from the applicable cost report for the patient care, ancillary and administration components, as set for in paragraphs (11)(A)1., (11)(B)1. and (11)(C)1., exceeds the per-diem ceiling for each cost component in effect at the end of the cost report period; and

(IV) State owned or operated facilities shall not be eligible for this adjustment.

B. The adjustment will be equal to ten percent (10%) of the sum of the per-diem ceilings for the patient care, ancillary and administration cost components in effect on July 1 of each year.

C. The division may reconstruct and redefine the qualifying criteria and payment methodology for the high volume adjustment.

11. Minimum Rate Adjustment. A minimum rate adjustment shall be granted to qualifying providers, as follows:

A. Effective for dates of service beginning July 1, 2001, the minimum Medicaid reimbursement rate for nursing facility services shall be $85.00.